Long-Term Care Task Force
Briefing Paper

Issue: Enhanced Health Insurance Options

Description: Some private health insurance policies provide additional benefits, such as chronic disease self-management programs, that can help enrollees become or remain relatively healthy, by offering structured avenues to engage individuals and increase compliance with recommended behaviors. By educating members about their ability to maintain a healthy lifestyle or manage a disease or its symptoms, these programs may help delay the onset of disease or the progression of disability. This briefing paper examines approaches used by private insurers and others for consideration in Washington.

Background: On one hand, many insurers have come to understand that an up front investment in keeping members healthy can have an impact on the prevalence and course of disease within an insurer's membership. As such, they have developed a variety of programs intended to improve a person's health, manage disease or promote a healthy lifestyle. For example, classes or programs an insurer may offer include:

- Smoking cessation
- Weight management and nutrition
- Eating disorders
- High blood pressure management
- Stress reduction
- Parenting/ prenatal education
- Behavioral health
- Support groups
- Aging well
- Disease management, for specific conditions

On the other hand, widespread adoption of such programs is mitigated partly by the financial benefit that can result from such programs. After all, on the private sector at least, financial viability and success does fuel these programs. This applies equally to the for-profit and non-profit sectors. The March/April 2003 Health Affairs article "the Business Case for Quality: Case Studies and an Analysis" explores short and long-term costs and benefits of quality improvement activities on stakeholders and recommend policy changes to align financial incentives for high quality of care.[1] The author rates the financial impact on stakeholders of each of the case studies (Attachment A, Exhibit 1) and provides recommendations focus on addressing specific impediments from payment, consumer perspectives on quality, disconnection between consumers and payers, and equal access to relevant information for clinicians for each stakeholder group (Attachment A, Exhibit 2).

[1] http://content.healthaffairs.org/cgi/content/full/22/2/17

Prevention and Healthy Living

Some insurers encourage healthy living by offering benefits such as a reduced cost gym membership for members. Smoking cession classes and stress management classes are also offered by some insurers.

Disease Management

Disease management programs, which are more common, typically focus on high-cost diseases and conditions, such as diabetes, asthma, and hypertension. These programs focus on education of members about recommended behaviors for care of their condition, with the goal of reducing the impact of the disease. For example, a disease management program that focuses on asthma may educate members on the proper use of maintenance medications, triggers, and early signs of asthma attacks. The program educates members on steps to take at the onset of an attack with the hope of avoiding emergency room visits. However, the extent to which these programs improve health status and reduce costs depends greatly on a variety of factors such as the intensity and consistency with which it is implemented and monitored, as well as the patient's adherence to the program's protocols.

Care or Case Management

For individuals with multiple chronic conditions, some insurers provide care or case management to assist the individual in coordinating between multiple specialty providers. Care management also varies depending on the source of coverage, whether Medicare, Medicaid or private insurance.

CHCS Integrated Care Program

The Integrated Care Program, which started in August 2005, provides technical assistance and training to states in the development of integrated care programs over a 2-year period. Five states receiving up to $100,000 include Washington's Medicaid Integration Partnership**,** Florida, Minnesota, New Mexico, and New York. Goals include integration of financing, care and administration of primary, acute, long-term care, chronic and behavioral health services for adults who are Medicaid and Medicare eligible. Efforts specifically focus on planning requirements for state contracts with Medicare Advantage Special Needs Plans.

Washington Examples

The following provide a sample of Washington specific examples of services through enhanced health insurance:

- **Washington Medicaid Integration Partnership**
    - 24-hour toll-free nurse advice line
    - Care coordination
    - Health education for diabetes and heart disease
    - Smoking cessation

- **PACE**
    - Adult day care for centralized client service delivery
    - Integration of medical, long-term care, alcohol and substance abuse treatment, and mental health services
    - Interdisciplinary team approach
- **Pursuing Perfection in Whatcom County**
    - Teach FFS clients to “self-manage” chronic conditions of diabetes and congestive heart failure
    - Assist clients improve health habits
    - Manage hard to reach, high-risk, high cost populations with diabetes and congestive heart failure
    - Service coordination across providers through case managers and shared electronic records and care plans
- **Mobility Project**
    - Intensive ADSA nurse case management to Medicaid patients with diagnosis that impact and impair client mobility
    - Focus on patients with MS, quadriplegia, paraplegia, or Parkinson’s’ disease for Medicaid only population

Potential Approach: Current initiatives are demonstrations. For those with demonstrated beneficial outcomes and cost savings, strategies to replicate these successes in other geographic areas and with other target populations could be pursued.

ATTACHMENT A

EXHIBIT 1
Financial Impact For Stakeholders In Four Cases

Case	Investigating organization	Care provider	Purchaser/ employer	Individual patients	Society
High-cost drugs					
LMWH	Provider	Unfavorable	Unfavorable	Favorable	Favorable
Lipid clinic	Provider	Unfavorable	Favorable	Favorable	Favorable
Diabetes management	Provider	Unfavorable	Favorable	Favorable	Favorable
Smoking cessation	Provider	Unfavorable	Neutral/unknown	Favorable	Favorable
Wellness program	Purchaser	Favorable	Favorable	Favorable	Favorable

SOURCE: Authors' analysis based on case studies.
NOTE: LMWH is low molecular weight heparin.

Source: Leatherman, et. al., "*The Business Case for Quality: Case Studies And An Analysis*", Volume 22, Number 2, Page 24, Health Affairs March/April, 2003

EXHIBIT 2
Possible Remedies In Organizational And Payer Policies

Impediment	Patients	Clinicians and organizations	Government and private payers
Failure to pay for quality, while paying for defects	Demand less underuse, overuse, and misuse	Offer quality guarantees Make performance information public Understand waste and continually reduce it in all operations	Pay differentially for sicker patients Put integrated care into the "core" Require performance reporting Extend Leapfrog standards to chronic illness care[a] Request guarantees Pay for nonvisit care
Inability of consumers to perceive quality differences	Demand reports on defect levels	Show performance publicly Explain and show new care models Explain defective nature of overuse of ineffective care Offer service guarantees	Educate the public on optimal care models (Open Access, Chronic Care Model) Release annual hospital-specific mortality data (CMS) Pay differentially for higher-cost patients
Displacements of payoffs in time and place	Choose best providers	Seek capitated payment Work on decreasing voluntary disenrollment rates	Offer capitated payment Unify Part A and Part B (CMS) Pay for case management Pay for nonvisit care Lengthen enrollment terms Increase disincentives to change caregivers Consider supporting and investing in "pre-Medicare" prevention and chronic care programs (CMS)
Disconnections between consumers and payers (administrative pricing)	Demand ability to pay for what is preferred, within a reasonable set of options	Mass-customize alternative forms of care	Experiment for paying for "features" under Medicare (such as e-mail visits) (CMS) Allow more choices to consumers (but without cost shifting) Encourage innovative care formats, especially for chronic disease
Uneven access to relevant information among clinicians	Learn science-based protocols and interact with physicians	Adopt electronic patient record Improve storage and retrieval systems Use registries, especially for the chronically ill Use reminders and decision supports	Support IT infrastructure development through capital financing Use market power to insist on spread of best practices

SOURCE: Authors' analysis based on case studies.
NOTES: CMS is Centers for Medicare and Medicaid Services. IT is information technology.
[a] See J.D. Birkmeyer et al., *Leapfrog Patient Safety Standards: The Potential Benefits of Universal Adoption* (Washington: Leapfrog Group, November 2000).

Source: Id, page 26.